

NEW PATIENT INFORMATION

PATIENT INFORMATION

Today's Date: _____

PATIENT NAME: _____

LAST FIRST MI PREferred

MALE FEMALE SINGLE MARRIED DIVORCED WIDOWED

PATIENT DOB: _____ **PATIENT SSN:** _____
 (Insurance Patients Only)

Address: _____

ADDRESS 1 _____

ADDRESS 2 _____

CITY ST ZIP CODE _____

E-Mail: _____

HOME: _____

CELL: _____

OTHER: _____

Referral? Yes No Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel: _____

EMPLOYMENT INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

ADDRESS LINE 1 _____

ADDRESS LINE 2 _____

CITY ST ZIP CODE _____

E-Mail: _____

WORK: _____ X

DIRECT: _____

OTHER: _____

PAGER: _____

FAX: _____

INSURANCE INFORMATION

Subscriber: _____

LAST FIRST MI

Subscriber Date of Birth: _____ **Subscriber SSN:** _____

Subscriber Employer: _____

Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER

PRIMARY INSURANCE CARRIER: _____

Group/Policy No.: _____ **ID No.:** _____

Address: _____

CITY ST ZIP CODE _____

TEL: _____

TOLL-FREE: _____

FAX: _____

SECONDARY INSURANCE CARRIER: _____

Group/Policy No.: _____ **ID No.:** _____

Address: _____

CITY ST ZIP CODE _____

TEL: _____

TOLL-FREE: _____

FAX: _____

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

MEDICAL HISTORY

- Y N Under a physician's care now?
- Y N Any hospitalization in the past 5 years? _____
- Y N Any serious illnesses/surgeries? _____
- Y N Use tobacco in any form? If Yes, Type: _____
- Y N Is pre-medication required before dental visits due to heart condition or artificial joint?
- Y N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: Y N Currently nursing? Y N Currently pregnant? Due Date: _____

Is there anything important about your medical condition we have not asked? Y N If yes, please describe: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

NONE

(CHECK ALL THAT APPLY):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> BULIMIA | <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> CANCER/MALIGNANCY | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> RADIATION/CHEMO |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> THYROID CONDITION |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> AUTISM/ASPERGER'S | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> PACEMAKER | |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> OTHER – PLEASE LIST: _____ | |

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

NONE

- | | | | |
|---|----------------------------------|---|---|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE | <input type="checkbox"/> SLEEPING PILLS |
| <input type="checkbox"/> ANESTHETIC – LOCAL | <input type="checkbox"/> DAIRY | <input type="checkbox"/> METAL SENSITIVITY | <input type="checkbox"/> SULFA DRUGS |
| <input type="checkbox"/> BARBITURATES | <input type="checkbox"/> LATEX | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS |
| <input type="checkbox"/> OTHER – PLEASE LIST: _____ | | | |

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

NONE

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN | <input type="checkbox"/> NITROGLYCERIN | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS |
| <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS |
| <input type="checkbox"/> OTHER (PLEASE LIST BELOW) | | | |

DRUG NAME	DOSAGE	REASON PRESCRIBED

I acknowledge that the questions have been answered to my satisfaction. I will not hold my dentist or staff responsible for any action that is a result of errors or omissions that I may have made on this form.

Signature of Patient/Legal Guardian: _____ Date _____

Reviewed by: _____
Doctors Signature

_____ Date

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ **Date:** _____

RELATIONSHIP TO PATIENT: SELF PARENT GUARDIAN OTHER _____

Prior Express Consent for Calls/Texts/Email: By providing the number of my land line, cell phone or other wireless device and my email address now or in the future, I expressly consent and agree that WISE DENTAL and any of its affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system or otherwise, leave me a voice, prerecorded, or artificial voice message, or send me a text, e-mail, or other electronic message for any purpose related to the servicing or collection of any account that I may establish with WISE DENTAL, or for other informational purposes related to my account or treatment ("Communication"). I also agree that WISE DENTAL and any of its affiliates, agents, service providers or assignees may include my personal information in a Communication. _____ **INITIAL**

FORMS OF COMMUNICATION: (check all that apply)

Home Phone Cell Phone Work Phone None- please just ask for a call back

Other (Please explain) _____

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

NAME

PHONE

DATE

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
 Communication barriers
 Emergency situation
 Other – please list: _____